		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035188

Facility Name: Lexington Health Care Center-Bloomingdale

Address: 165 S. Bloomingdale Road (Number) Bloomingdale (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630) 980-8700 **Fax #** (630) 980-6170

IDPA ID Number: 363635151001

Date of Initial License for Current Owners: 05/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	172	Skilled (SNF)	172	62,780	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	62,780	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,789	6,150	6,230	26,169	8
9	SNF/PED					9
10	ICF	14,505	3,256	1,215	18,976	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,294	9,406	7,445	45,145	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.91%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 5,396

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	271,888	23,182	10,869	305,939		305,939		305,939			1
2	Food Purchase		186,404		186,404		186,404	(9,590)	176,814			2
3	Housekeeping	299,693	28,169		327,862		327,862	592	328,454			3
4	Laundry		16,246		16,246		16,246	(3,732)	12,514			4
5	Heat and Other Utilities			198,199	198,199		198,199	3,161	201,360			5
6	Maintenance	57,212		102,198	159,410		159,410	4,102	163,512			6
7	Other (specify):*											7
8	**TOTAL General Services**	628,793	254,001	311,266	1,194,060		1,194,060	(5,467)	1,188,593			8
	B. Health Care and Programs											
9	Medical Director			9,350	9,350		9,350		9,350			9
10	Nursing and Medical Records	2,332,823	169,909	60,760	2,563,492		2,563,492		2,563,492			10
10a	Therapy			519,038	519,038		519,038		519,038			10a
11	Activities	140,189	9,435	2,256	151,880		151,880		151,880			11
12	Social Services	79,121		5,100	84,221		84,221		84,221			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,552,133	179,344	596,504	3,327,981		3,327,981		3,327,981			16
	C. General Administration											
17	Administrative	155,621		295,732	451,353		451,353	(295,732)	155,621			17
18	Directors Fees											18
19	Professional Services			45,841	45,841		45,841	6,870	52,711			19
20	Dues, Fees, Subscriptions & Promotions			11,287	11,287		11,287	1,178	12,465			20
21	Clerical & General Office Expenses	377,916	25,945	38,586	442,447		442,447	7,990	450,437			21
22	Employee Benefits & Payroll Taxes			441,553	441,553		441,553	56,101	497,654			22
23	Inservice Training & Education			763	763		763		763			23
24	Travel and Seminar			3,429	3,429		3,429	2,482	5,911			24
25	Other Admin. Staff Transportation			10	10		10	8,139	8,149			25
26	Insurance-Prop.Liab.Malpractice			125,134	125,134		125,134	2,704	127,838			26
27	Other (specify):*											27
28	**TOTAL General Administration**	533,537	25,945	962,335	1,521,817		1,521,817	(210,268)	1,311,549			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,714,463	459,290	1,870,105	6,043,858		6,043,858	(215,735)	5,828,123			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale #0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			57,367	57,367		57,367	184,872	242,239			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,099	7,099		7,099	318,106	325,205			32
33	Real Estate Taxes							127,377	127,377			33
34	Rent-Facility & Grounds			1,085,600	1,085,600		1,085,600	(1,085,600)				34
35	Rent-Equipment & Vehicles			2,314	2,314		2,314	3,738	6,052			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,152,380	1,152,380		1,152,380	(451,507)	700,873			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,174	34,775	143,949		143,949		143,949			39
40	Barber and Beauty Shops			13,529	13,529		13,529		13,529			40
41	Coffee and Gift Shops			1,468	1,468		1,468		1,468			41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):* Nonallowable Costs			39,598	39,598		39,598	(39,598)				43
44	**TOTAL Special Cost Centers**		109,174	183,540	292,714		292,714	(39,598)	253,116			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,714,463	568,464	3,206,025	7,488,952		7,488,952	(706,840)	6,782,112			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,732)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(261)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(894)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,188)	43		24
25	Fund Raising, Advertising and Promotional	(17,491)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,552)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(500,491)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (546,639)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(160,201)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (160,201)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (706,840)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lexington Health Care Center-Bloomingdale

ID# 0035188

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/02 - 12/31/02 **Schedule A**

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(1,156)	19
Out of period professional fees	(264)	19
Disallow Chamber of Commerce Dues	(395)	20
Offset miscellaneous income	(453)	21
Nonallowable miscellaneous expense	(12,085)	21
Unrealized loss resulting from interest rate swap	(489,370)	43
Deferred maintenance amortization	3,232	6
Total	(500,491)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington Health Care Center-Bloomingdale **#** 0035188 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5)	0	0	0	0	0	0	0	0	0	0	(5)	2
3	Housekeeping	0	0	592	0	0	0	0	0	0	0	0	592	3
4	Laundry	(3,732)	0	0	0	0	0	0	0	0	0	0	(3,732)	4
5	Heat and Other Utilities	0	0	3,161	0	0	0	0	0	0	0	0	3,161	5
6	Maintenance	0	0	870	0	0	0	0	0	0	0	0	870	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,737)	0	4,623	0	0	0	0	0	0	0	0	886	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(295,732)	0	0	0	0	0	0	0	(295,732)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	90	8,200	0	0	0	0	0	0	0	0	8,290	19
20	Fees, Subscriptions & Promotions	0	0	1,573	0	0	0	0	0	0	0	0	1,573	20
21	Clerical & General Office Expenses	0	1,111	19,417	0	0	0	0	0	0	0	0	20,528	21
22	Employee Benefits & Payroll Taxes	0	0	46,516	0	0	0	0	0	0	0	0	46,516	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,482	0	0	0	0	0	0	0	0	2,482	24
25	Other Admin. Staff Transportation	0	0	0	8,139	0	0	0	0	0	0	0	8,139	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,704	0	0	0	0	0	0	0	2,704	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	1,201	78,188	(284,889)	0	0	0	0	0	0	0	(205,500)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,737)	1,201	82,811	(284,889)	0	0	0	0	0	0	0	(204,614)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	162,944	0	21,928	0	0	0	0	0	0	0	184,872	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(261)	314,819	0	3,548	0	0	0	0	0	0	0	318,106	32
33	Real Estate Taxes	0	125,600	0	1,777	0	0	0	0	0	0	0	127,377	33
34	Rent-Facility & Grounds	0	(1,085,600)	0	0	0	0	0	0	0	0	0	(1,085,600)	34
35	Rent-Equipment & Vehicles	0	0	0	3,738	0	0	0	0	0	0	0	3,738	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(261)	(482,237)	0	30,991	0	0	0	0	0	0	0	(451,507)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(42,150)	491,922	0	0	0	0	0	0	0	0	0	449,772	43
44	**TOTAL Special Cost Centers**	(42,150)	491,922	0	0	0	0	0	0	0	0	0	449,772	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(46,148)	10,886	82,811	(253,898)	0	0	0	0	0	0	0	(206,349)	45

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Bloomingdale		
See attached Schedule B		See attached Schedule B		Limited Partnership	Bloomingdale	Real estate ptsp.
				Royal Mgmt. Corp	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,085,600	Sambell of Bloomingdale Limited Partnership	**	$	$ (1,085,600)	1
2	V	19	Professional fees		Sambell of Bloomingdale Limited Partnership	**	90	90	2
3	V	21	Bank charges		Sambell of Bloomingdale Limited Partnership	**	49	49	3
4	V	21	Administrative expenses		Sambell of Bloomingdale Limited Partnership	**	957	957	4
5	V	21	Office supplies		Sambell of Bloomingdale Limited Partnership	**	105	105	5
6	V	30	Depreciation		Sambell of Bloomingdale Limited Partnership	**	162,944	162,944	6
7	V	32	Interest expense		Sambell of Bloomingdale Limited Partnership	**	310,188	310,188	7
8	V	32	Amortization of mortgage costs		Sambell of Bloomingdale Limited Partnership	**	4,631	4,631	8
9	V	33	Property taxes		Sambell of Bloomingdale Limited Partnership	**	125,600	125,600	9
10	V	43	State replacement tax		Sambell of Bloomingdale Limited Partnership	**	2,552	2,552	10
11	V	43	Unrealized loss		Sambell of Bloomingdale Limited Partnership	**	489,370	489,370	11
12	V				** Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100%				12
13	V				of Sambell of Bloomingdale Limited Partnership				13
14	Total			$ 1,085,600			$ 1,096,486	$ * 10,886	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188 **Schedule B**
1/1/02 - 12/31/02

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 592	$ 592	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,011	3,011	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	150	150	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	820	820	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	37	37	19
20	V	6	Security service		Royal Management Corp.	**	13	13	20
21	V	19	Computer consultant & supplies		Royal Management Corp.	**	6,533	6,533	21
22	V	19	Professional fees		Royal Management Corp.	**	1,667	1,667	22
23	V	20	Advertising - help wanted		Royal Management Corp.	**	946	946	23
24	V	20	Dues & subscriptions		Royal Management Corp.	**	627	627	24
25	V	21	Bank charges		Royal Management Corp.	**	2,180	2,180	25
26	V	21	Communications		Royal Management Corp.	**	436	436	26
27	V	21	Office supplies & printing		Royal Management Corp.	**	8,260	8,260	27
28	V	21	Postage		Royal Management Corp.	**	2,594	2,594	28
29	V	21	Telephone		Royal Management Corp.	**	5,947	5,947	29
30	V	22	FICA		Royal Management Corp.	**	25,073	25,073	30
31	V	22	FUTA		Royal Management Corp.	**	461	461	31
32	V	22	SUTA		Royal Management Corp.	**	503	503	32
33	V	22	Insurance - W/C		Royal Management Corp.	**	581	581	33
34	V	22	Insurance - hospitalization		Royal Management Corp.	**	14,585	14,585	34
35	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	5,313	5,313	35
36	V	24	Travel & seminar		Royal Management Corp.	**	2,482	2,482	36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 82,811	$ * 82,811	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 8,139	$ 8,139	15
16	V	26	Insurance - general		Royal Management Corp.	**	2,704	2,704	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	2,903	2,903	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	5,702	5,702	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	13,323	13,323	19
20	V	32	Interest		Royal Management Corp.	**	3,548	3,548	20
21	V	33	Property taxes		Royal Management Corp.	**	1,777	1,777	21
22	V	35	Equipment rental		Royal Management Corp.	**	3,738	3,738	22
23	V	17	Management fees	295,732	Royal Management Corp.	**		(295,732)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Bloomingdale, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 295,732			$ 41,834	$ * (253,898)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdal # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	4	9%	Salary	$ 30,638	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	10%	Salary	13,617	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	10%	Salary	17,021	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	10%	Salary	4,085	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6%	Salary	10,318	L17, C1	5
6											6
7											7
8				All individuals worked in excess of 40 hours per week							8
9											9
10											10
11											11
12											12
13								TOTAL	$ 75,679		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188 **Schedule C**
1/1/02 - 12/31/02

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Chicago Ridge, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Elmhurst, Inc.	11,875	26,719	14,844	3,563	8,998	65,999
Lexington Health Care Center of LaGrange, Inc.	8,629	19,416	10,787	2,589	6,538	47,959
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Lombard, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Orland Park, Inc.	21,376	48,096	26,721	6,413	16,194	118,800
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Streamwood, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Wheeling, Inc.	17,496	39,367	21,870	5,249	13,258	97,240
Total	146,383	329,362	182,979	43,915	110,913	813,552

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 6,954	$	62,780	$ 592	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380		62,780	3,011	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765		62,780	150	3
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640		62,780	820	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	438		62,780	37	5
6	6	Security service	Bed Days	737,665	10	150		62,780	13	6
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767		62,780	6,533	7
8	19	Professional fees	Bed Days	737,665	10	19,590		62,780	1,667	8
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111		62,780	946	9
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373		62,780	627	10
11	21	Bank charges	Bed Days	737,665	10	25,613		62,780	2,180	11
12	21	Communications	Bed Days	737,665	10	5,118		62,780	436	12
13	21	Office supplies & printing	Bed Days	737,665	10	97,051		62,780	8,260	13
14	21	Postage	Bed Days	737,665	10	30,484		62,780	2,594	14
15	21	Telephone	Bed Days	737,665	10	69,873		62,780	5,947	15
16	22	FICA	Bed Days	737,665	10	294,613		62,780	25,073	16
17	22	FUTA	Bed Days	737,665	10	5,419		62,780	461	17
18	22	SUTA	Bed Days	737,665	10	5,907		62,780	503	18
19	22	Insurance - W/C	Bed Days	737,665	10	6,829		62,780	581	19
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371		62,780	14,585	20
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427		62,780	5,313	21
22	24	Travel & seminar	Bed Days	737,665	10	29,161		62,780	2,482	22
23										23
24										24
25	TOTALS					$ 973,034	$		$ 82,811	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 95,636	$	62,780	$ 8,139	1
2	26	Insurance - general	Bed Days	737,665	10	31,776		62,780	2,704	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112		62,780	2,903	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995		62,780	5,702	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541		62,780	13,323	5
6	32	Interest	Bed Days	737,665	10	41,692		62,780	3,548	6
7	33	Property taxes	Bed Days	737,665	10	20,881		62,780	1,777	7
8	35	Equipment rental	Bed Days	737,665	10	43,917		62,780	3,738	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 491,550	$		$ 41,834	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C.	x		Mortgage	Varies	2/1/96	5,575,000	4,677,500	02/01/2026	Variable	310,188	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	x		Working Capital	None	Various	744,845	147,945	Demand	0.0300	4,000	6
7	Lasalle Bank N. A.		x	Working Capital	Varies	4/24/02	600,000	250,000	04/05/03	Variable	3,099	7
8												8
9	TOTAL Facility Related						$ 6,919,845	$ 5,075,445			$ 317,287	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			4,631	10
11								Interest Income offset			(261)	11
12								Management company allocation			3,548	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,918	14
15	TOTALS (line 9+line14)						$ 6,919,845	$ 5,075,445			$ 325,205	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 120,000	1
	Allocated from management company	1,777	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 119,600	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,377	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 126,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 127,377	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	112,356	8
	1998	114,528	9
	1999	114,820	10
	2000	116,303	11
	2001	119,600	12

2001 tax:	119,600
Estimated increase:	1.055
Estimated 2002 taxes:	126,178
Use:	126,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington Health Care Center-Bloomingdal COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0035188

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-401-003	Land and building	$ 119,600.20	$ 119,600.20
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 70,162.04	$ 124.00
4.	Royal Management Corp. (Samvest		$	$
5.	05-01-202-019	Land and building	$ 144,399.48	$ 1,653.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 334,161.72	$ 121,377.20

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,554 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	43,000	1987	$ 402,548	1
2	Management Company allocation			13,856	2
3	TOTALS	43,000		$ 416,404	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1989	1989	$ 2,980,863	$	35	$ 85,192	$ 85,192	$ 1,164,291	4
5	9		1992	1992	178,974		35	5,114	5,114	56,251	5
6	75		1994	1994	2,022,894		35	57,797	57,797	491,274	6
7											7
8											8
	Improvement Type**										
9	Capitalized repairs			1989	9,080		10			9,080	9
10	Building Improvements			1990	3,674		10			3,674	10
11	Building Improvements			1991	2,586		10			2,586	11
12	Building Improvements			1992	3,154	157	10	157		3,154	12
13	Building Improvements			1993	1,582	158	10	158		1,503	13
14	Building Improvements			1994	15,734	1,573	10	1,573		13,374	14
15	Land Improvements			1994	1,381	138	10	138		1,174	15
16	Land Improvements			1995	1,074		15	72	72	537	16
17	Building Improvements			1995	1,288		35	37	37	293	17
18	Building Improvements			1995	9,433	270	35	270		2,025	18
19	Building Improvements			1995	43,839	1,252	35	1,252		9,390	19
20	Concrete flooring, fire doors, tile, sprinkler heads,										20
21	and basement renovation			1996	8,706	298	10-35	298		1,938	21
22	Land Improvements - drain tile system			1996	7,858		15	524	524	3,405	22
23	Resident room heaters			1997	3,563	102	35	102		611	23
24	Automatic doors			1997	12,950	370	35	370		1,881	24
25	Basement renovation			1997	58,806	5,936	10	5,936		30,668	25
26	Land Improvement - outdoor flagpoles			1997	1,574	105	15	105		577	26
27	1st Floor Remodel (Nurses Station/Lounge)			1998	76,487	7,649	10	7,649		34,419	27
28	Wiring for MDS			1998	4,506	451	10	451		2,028	28
29	Flag Pole			1998	787	79	10	79		354	29
30	Resurface/Stripe Parking Lot			1998	9,777	978	10	978		4,400	30
31	Kitchen tile/paint			1999	718	72	10	72		251	31
32	1st Floor Remodel			1999	3,296	330	10	330		1,318	32
33	Roof repairs			2000	5,748	383	15	383		958	33
34	Sump pump			2000	2,534	253	10	253		634	34
35	Sump pump basin repair			2000	6,306	631	10	631		1,577	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Automatic door closers	2000	$ 1,300	$ 87	15	$ 87	$	$ 217	37
38	Parking lot seal and restripe	2001	2,473	247	10	247		371	38
39	Infrared curtains for elevator doors	2001	3,000	300	10	300		450	39
40	Ejector pump	2002	3,050	559	5	559		559	40
41	Lift station pump	2002	3,359	224	5	224		224	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50	Leasehold improvements - management company	1995	8,782		35	319	319	1,882	50
51	Leasehold improvements - management company	1996	7,147		35	259	259	1,327	51
52	Leasehold improvements - management company	1989	246		31	9	9	116	52
53	HVAC - management company	1998	185		35	7	7	26	53
54	Offices - management company	1999	467		35	17	17	47	54
55	Offices - management company	2000	222		35	8	8	17	55
56	Land improvements - management company	2002	8,311		15	508	508	508	56
57	Building - management company	2002	193,761		40	4,440	4,440	4,440	57
58	Sewer & water improvements - management company	2002	4,407		30	135	135	135	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,715,882	$ 22,602		$ 177,040	$ 154,438	$ 1,853,944	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 427,817	$ 34,444	$ 48,493	$ 14,049	5-10 years	$ 257,703	71
72	Current Year Purchases	8,556	480	480		5-10 years	480	72
73	Fully Depreciated Assets	268,491					268,491	73
74	Allocated from Mgmt. Co.	133,062		13,323	13,323		34,804	74
75	TOTALS	$ 837,926	$ 34,924	$ 62,296	$ 27,372		$ 561,478	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Mgmt. Co.			25,986		2,903	2,903		18,083	79
80	TOTALS			$ 25,986	$	$ 2,903	$ 2,903		$ 18,083	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,996,198	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 57,526	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 242,239	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 184,713	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,433,505	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Rehabilitation	$ 75,818	92
93			93
94			94
95		$ 75,818	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 6,052 Description: Postage meter: $564; Copier: $1,480; Fax: $270; Allocated from management company: $3,738
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	17,445	$ 205,698	$	17,445	$ 205,698	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		2,667	48,306		2,667	48,306	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		18,377	265,034		18,377	265,034	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				109,174		109,174	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					34,775			34,775	13
14	TOTAL			$	38,489	$ 553,813	$ 109,174	38,489	$ 662,987	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/02 - 12/31/02 **Schedule D**

XIV. Special Services (Direct Cost)
Line 13, Other

Service	Cost	Line Reference
Oxygen	16,804	L 39, C3
Laboratory	2,010	L 39, C3
Radiology	2,254	L 39, C3
Clinitron beds	13,707	L 39, C3
Total	34,775	

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 112,414	$ 114,035	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 371,377)	1,406,992	1,406,992	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,315	47,315	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	54,554	53,632	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,621,275	$ 1,621,974	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	52,824	52,824	12
13	Land		416,404	13
14	Buildings, at Historical Cost		5,182,731	14
15	Leasehold Improvements, at Historical Cost	290,323	533,151	15
16	Equipment, at Historical Cost	341,293	863,912	16
17	Accumulated Depreciation (book methods)	(305,334)	(2,433,505)	17
18	Deferred Charges		1,279	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	75,818	75,818	22
23	Other(specify): Unamortized Loan Costs		86,665	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 454,924	$ 4,779,279	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,076,199	$ 6,401,253	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 235,010	$ 235,010	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	213,075	213,075	28
29	Short-Term Notes Payable	147,945	147,945	29
30	Accrued Salaries Payable	168,812	168,812	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,096	4,096	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,000	32
33	Accrued Interest Payable		38,077	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	293,540	72,592	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,062,478	$ 1,005,607	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	250,000	250,000	39
40	Mortgage Payable		4,677,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Interest Rate Swap		489,370	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 250,000	$ 5,416,870	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,312,478	$ 6,422,477	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 763,721	$ (21,224)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,076,199	$ 6,401,253	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/02 - 12/31/02 **Schedule E**

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	220,948	-
Accrued management fees	17,474	17,474
Accrued 401 (k) contribution	8,743	8,743
401 (k) withholding	2,645	2,645
Due from related party	896	896
Other accrued expenses	42,834	42,834
Total line 36	293,540	72,592

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous income	453
Investment income in Lexington Financial Services, L.L.	736
Total line 28	1,189

See Accountants' Compilation Report

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,221,213	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(60,294)	3
4	**Prior year's post closing entries**	(193,946)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 966,973	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(203,252)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (203,252)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 763,721	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,531,317	1
2	Discounts and Allowances for all Levels	(381,142)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,150,175	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	897,542	6
7	Oxygen	3,115	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 900,657	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,502	12
13	Barber and Beauty Care	15,914	13
14	Non-Patient Meals	5	14
15	Telephone, Television and Radio	33	15
16	Rental of Facility Space		16
17	Sale of Drugs	137,291	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,966	19
20	Radiology and X-Ray	3,218	20
21	Other Medical Services	57,757	21
22	Laundry	3,732	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 233,418	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	261	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 261	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attached Schedule 17 E	1,189	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,189	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,285,700	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,194,060	31
32	Health Care	3,327,981	32
33	General Administration	1,521,817	33
	B. Capital Expense		
34	Ownership	1,152,380	34
	C. Ancillary Expense		
35	Special Cost Centers	198,544	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,488,952	40
41	**Income before Income Taxes (line 30 minus line 40)****	(203,252)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (203,252)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,207	2,304	$ 85,451	$ 37.09	1
2	Assistant Director of Nursing	1,375	1,555	42,432	27.29	2
3	Registered Nurses	39,365	41,632	1,111,910	26.71	3
4	Licensed Practical Nurses	3,260	3,331	76,813	23.06	4
5	Nurse Aides & Orderlies	75,681	78,171	889,166	11.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,785	9,217	127,051	13.78	8
9	Activity Director	1,689	1,919	28,392	14.80	9
10	Activity Assistants	12,112	12,665	111,797	8.83	10
11	Social Service Workers	4,037	4,279	79,121	18.49	11
12	Dietician					12
13	Food Service Supervisor	1,966	2,070	32,750	15.82	13
14	Head Cook	1,950	2,070	25,950	12.54	14
15	Cook Helpers/Assistants	15,489	16,342	139,674	8.55	15
16	Dishwashers	11,429	11,779	73,514	6.24	16
17	Maintenance Workers	3,705	3,902	57,212	14.66	17
18	Housekeepers	42,217	44,437	299,693	6.74	18
19	Laundry					19
20	Administrator	2,176	2,245	79,942	35.61	20
21	Assistant Administrator					21
22	Other Administrative	567	567	75,679	133.47	22
23	Office Manager					23
24	Clerical	19,909	21,185	377,916	17.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	247,919	259,670	$ 3,714,463 *	$ 14.30	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	174	$ 9,690	L1, C3	35
36	Medical Director	Monthly	9,350	L9, C3	36
37	Medical Records Consultant	14	675	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	2,256	L11, C3	44
45	Social Service Consultant	50	2,250	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	250	$ 25,421		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,707	$ 54,136	L10, C3	50
51	Licensed Practical Nurses	100	1,797	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,807	$ 55,933		53

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Goodall	Administrator	0%	$ 79,942
John Samatas	Admin/Plant Ops	22.33%	13,617
James Samatas	Administrative	22.33%	30,638
Cynthia Thiem	Administrative	22.34%	17,021
George Samatas	Administrative	0%	4,085
Jason Samatas	Administrative	0%	10,318
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 155,621

B. Administrative - Other

Description	Amount
	$
Management fees (eliminated in column 7)	295,732
TOTAL (agree to Schedule V, line 17, col. 3)	$ 295,732
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ING	401(k) Administration	$ 345
Altschuler, Melvoin & Glasser LLP	Accounting	19,954
American Express Tax & Bus. Svcs.	Accounting	5,661
Arete 3 LTD.	Architectural Consultant	1,418
Katten, Muchin, Zavis, Rosenman	Legal	868
Harris, Kessler & Goldstein	Legal	2,589
James Samatas	Legal	127
Personnel Planners	U/C Consulting	870
Carol Jeschke	Staffing Consultant	738
Sachnoff & Weaver	Legal	3,691
Systematic Management	Billing Consulting	940
See attached Schedule F		8,640
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,841

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,049
Unemployment Compensation Insurance	33,497
FICA Taxes	273,943
Employee Health Insurance	96,635
Employee Meals	9,585
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	11,334
Other employee benefits	6,611
TOTAL (agree to Schedule V, line 22, col.8)	$ 497,654

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	7,594
Health Care Worker Background Check	
(Indicate # of checks performed 33)	396
Miscellaneous Permits & Fees	1,210
Miscellaneous Dues & Subscriptions	1,292
Allocated from management company	1,573
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,465

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,429
Allocated from management company	2,482
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,911

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Bloomingdale, Inc.
Provider # 0035188
1/1/02 - 12/31/02

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee		
Internet Presence Consulting	Computer Consulting	711
Information Controls Inc.	Computer Consulting	650
Answers On Demand	Computer Consulting	3,247
XO Communication	Computer Consulting	1,521
Action Computer Service, Inc.	Computer Consulting	324
Gigatrend	Computer Consulting	195
Tri Com Computer Inc.	Computer Consulting	222
Global Care	IOC Consulting	264
Glantz-Richman	Rehabilitation Consultant	350
Freedman, Anselmo & Lindberg	Collections	1,156
		8,640
Total, Agrees to Schedule V, Line 19, Column 3		45,841
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	621
Brekke Consulting, Inc.	Exec. Counsel Consulting	143
Gilson, Labus and Silverman	Accounting	39
James Samatas	Legal	17
Katten, Muchin, Zavis and Rosenman	Legal	188
Sachnoff and Weaver	Legal	103
ING / Pension Administrators / Aetna Life Insurance & Annuity Co.	401 (k) Administration	461
Various	Consulting	6,628
Allocated from building partnership		
James Samatas	Annual report	90
Nonallowable legal fees		
Freedman, Anselmo & Lindberg	Collections	(1,156)
Out of period professional fees		
Global Care Consulting	IOC Consulting	(264)
Total, Agrees to Schedule V, Line 19, Column 8		52,711

See accountants' compilation report.

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Deferred Maintenance	2/1999	$ 4,043	3	$ 674	$ 1,348	$ 1,348	$ 673	$	$	$	$	$
2	Painting & Decorating	Various, 2000	7,676	3		1,279	2,559	2,559	1,279				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,719		$ 674	$ 2,627	$ 3,907	$ 3,232	$ 1,279	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington Health Care Center-Bloomingdale # 0035188 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **40,241** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **94,170**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **9,585** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **5**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington Health Care C** **03:21 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-706,840	equal to	-706,840	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	325,205	equal to	325,205	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	127,377	equal to	127,377	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	242,239	equal to	242,239	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,052	equal to	6,052	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	519,038	equal to	519,038	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	109,174	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,194,060	equal to	1,194,060	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,327,981	equal to	3,327,981	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,521,817	equal to	1,521,817	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,152,380	equal to	1,152,380	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	198,544	equal to	198,544	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	94,170	equal to	94,170	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,205,772	equal to	2,332,823	-127,051	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	140,189	equal to	140,189	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	79,121	equal to	79,121	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	271,888	equal to	271,888	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	57,212	equal to	57,212	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	299,693	equal to	299,693	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	155,621	equal to	155,621	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	377,916	equal to	377,916	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,714,463	equal to	3,714,463	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,690	< or = to	10,869	-1,179	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,350	< or = to	9,350	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	57,808	< or = to	60,760	-2,952	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,256	< or = to	2,256	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,250	< or = to	5,100	-2,850	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	155,621	equal to	155,621	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	295,732	equal to	295,732	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	45,841	equal to	45,841	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	497,654	equal to	497,654	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	12,465	equal to	12,465	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,911	equal to	5,911	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	94,170	equal to	94,170	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	9,585	< or = to	56,101	-46,516	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	9,585	equal to	9,585	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,396	equal to	6,230	-834	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-160,201	equal to	-160,201	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,075,445	equal to	5,075,445	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	126,000	equal to	126,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	416,404	equal to	416,404	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	5,715,882	equal to	5,715,882	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	863,912	equal to	863,912	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,433,505	equal to	2,433,505	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	763,721	equal to	763,721	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-203,252	equal to	-203,252	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	1,279	equal to	1,279	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,076,199	equal to	2,076,199	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	271,888	23,182	10,869	305,939	0	305,939	0	305,939
2. Food P	0	186,404	0	186,404	0	186,404	-9,590	176,814
3. Housek	299,693	28,169	0	327,862	0	327,862	592	328,454
4. Laundry	0	16,246	0	16,246	0	16,246	-3,732	12,514
5. Heat ar	0	0	198,199	198,199	0	198,199	3,161	201,360
6. Mainter	57,212	0	102,198	159,410	0	159,410	4,102	163,512
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	628,793	254,001	311,266	1,194,060	0	1,194,060	-5,467	1,188,593
9. Medical	0	0	9,350	9,350	0	9,350	0	9,350
10. Nursin	2,332,823	169,909	60,760	2,563,492	0	2,563,492	0	2,563,492
10a. Ther	0	0	519,038	519,038	0	519,038	0	519,038
11. Activit	140,189	9,435	2,256	151,880	0	151,880	0	151,880
12. Social	79,121	0	5,100	84,221	0	84,221	0	84,221
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	2,552,133	179,344	596,504	3,327,981	0	3,327,981	0	3,327,981
17. Admin	155,621	0	295,732	451,353	0	451,353	-295,732	155,621
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	45,841	45,841	0	45,841	6,870	52,711
20. Fees,	0	0	11,287	11,287	0	11,287	1,178	12,465
21. Clerica	377,916	25,945	38,586	442,447	0	442,447	7,990	450,437
22. Emplo	0	0	441,553	441,553	0	441,553	56,101	497,654
23. Inserv	0	0	763	763	0	763	0	763
24. Travel	0	0	3,429	3,429	0	3,429	2,482	5,911
25. Other	0	0	10	10	0	10	8,139	8,149
26. Insura	0	0	125,134	125,134	0	125,134	2,704	127,838
27. Other	0	0	0	0	0	0	0	0
28. Total (	533,537	25,945	962,335	1,521,817	0	1,521,817	-210,268	1,311,549
29. Total (	3,714,463	459,290	1,870,105	6,043,858	0	6,043,858	-215,735	5,828,123
30. Depre	0	0	57,367	57,367	0	57,367	184,872	242,239
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	7,099	7,099	0	7,099	318,106	325,205
33. Real E	0	0	0	0	0	0	127,377	127,377
34. Rent -	0	0	1,085,600	1,085,600	0	1,085,600	########	0
35. Rent -	0	0	2,314	2,314	0	2,314	3,738	6,052
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	1,152,380	1,152,380	0	1,152,380	-451,507	700,873
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	109,174	34,775	143,949	0	143,949	0	143,949
40. Barber	0	0	13,529	13,529	0	13,529	0	13,529
41. Coffee	0	0	1,468	1,468	0	1,468	0	1,468
42. Provid	0	0	94,170	94,170	0	94,170	0	94,170
43. Other	0	0	39,598	39,598	0	39,598	-39,598	0
44. Total S	0	109,174	183,540	292,714	0	292,714	-39,598	253,116
45. Grand	3,714,463	568,464	3,206,025	7,488,952	0	7,488,952	-706,840	6,782,112

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	112,414	114,035
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,406,992	1,406,992
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	47,315	47,315
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	54,554	53,632
9. Other (specify):	0	0
10. Total current assets	1,621,275	1,621,974
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	52,824	52,824
13. Land	0	416,404
14. Buildings, at Historical Cost	0	5,182,731
15. Leasehold Improvements, Historical Cost	290,323	533,151
16. Equipment, at Historical Cost	341,293	863,912
17. Accumulated Depreciation (book methods)	-305,334	-2,433,505
18. Deferred Charges	0	1,279
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	75,818	75,818
23. other (specify):	0	86,665
24. Total Long-Term Assets	454,924	4,779,279
25. Total Assets	2,076,199	6,401,253
CURRENT LIABILITIES		
26. Accounts Payable	235,010	235,010
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	213,075	213,075
29. Short-Term Notes Payable	147,945	147,945
30. Accrued Salaries Payable	168,812	168,812
31. Accrued Taxes Payable	4,096	4,096
32. Accrued Real Estate Taxes	0	126,000
33. Accrued Interest Payable	0	38,077
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	293,540	72,592
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,062,478	1,005,607
LONG TERM LIABILITES		
39.Long-Term Notes Payable	250,000	250,000
40.Mortgage Payable	0	4,677,500
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	489,370
45.Total Long-Term Liabilities	250,000	5,416,870
46.Total Liabilities	1,312,478	6,422,477
47.Total Equity	763,721	-21,224
48.Total Liabilities and Equity	2,076,199	6,401,253

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,531,317
2. Discounts and Allowances for all Levels	-381,142
Subtotal - Inpatient Care	6,150,175
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	897,542
7. Oxygen	3,115
Subtotal - Anciliary Revenue	900,657
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	1,502
13. Barber and Beauty Care	15,914
14. Non-Patient Meals	5
15. Telephone, Television, and Radio	33
16. Rental of Facility Space	0
17. Sale of Drugs	137,291
18. Sale of Supplies to Non-Patients	0
19. Laboratory	13,966
20. Radiologyand X-Ray	3,218
21. Other Medical Services	57,757
22. Laundry	3,732
Subtotal - Other Operating Revenue	233,418
24. Contributions	0
25. Interest and Other Investments Income	261
Subtotal - Non-Operating Revenue	261
27. Other Revenue (specify):	1,189
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,189
30. Total Revenue	7,285,700
31. General Services	1,194,060
32. Health Care	3,327,981
33. General Administration	1,521,817
34. Ownership	1,152,380
35. Special Cost Centers	198,544
35. Provider Participation Fee	94,170
37. Other	0
40. Total Expenses	7,488,952
41. Income Before Income Taxes	-203,252
42. Income Taxes	0
43. Net Income or Loss for the Year	-203,252

Page

Line 16 for mortgage insurance.